CC-024-PF (11-06)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Child Care Administration

Reset Form

EMPLOYMENT AND WAGE VERIFICATION STATEMENT

The employee below has been requested to provide the following information to the child care specialist. The information that you provide will be used for Child Care Program eligibility determination. Please provide the information in order to assist your employee. If you have any questions regarding the use of this form or the information requested, please contact the child care specialist.

EMPLOYER'S NAME AND ADDRESS
•

The person named below has authorized the release of the information requested. The information provided will become part of a permanent file with access limited to representatives of DES and the employee named.

EMPLOYEE' S NAME *(Last, First, M.I.)*	SOC. SEC. NO.

I am authorizing the above-named organization or person to release the information requested.

EMPLOYEE' S SIGNATURE

EMPLOYEE INFORMATION *(TO BE COMPLETED BY THE EMPLOYER)*

HOURS

NO. HOURS WORKED PER WEEK *(If hours. per week vary, indicate the average per week)*	NO. HOURS WORKED PER DAY *(If hours per day vary, indicate the range possible)* From: To:

DAYS OF WEEK WORKED *(Check all that apply)*

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

WAGES

FREQUENCY PAID *(Check one)*

☐ Weekly ☐ Bi-weekly *(every two weeks)* ☐ Semi-monthly *(twice per month)* ☐ Other

HOURLY WAGE	HOURLY OVERTIME WAGE *(If applicable)*	TIPS/COMMISSIONS RECEIVED *(If applicable)*
$	$	$ per

NAME OF PERSON COMPLETING FORM *(Type or print)*	JOB TITLE

SIGNATURE OF PERSON COMPLETING FORM	PHONE NO.	DATE
	( )	

IF NEWLY EMPLOYED

DATE STARTED	DATE OF FIRST CHECK	DATE OF FIRST *FULL* CHECK	GROSS AMOUNT OF FIRST FULL CHECK
			$

IF NO LONGER EMPLOYED

LAST DATE WORKED	DATE LAST WAGES RECEIVED	GROSS AMOUNT OF LAST WAGES RECEIVED
		$

TERMINATION DATE	TERMINATION STATUS *(Check one)*
	☐ Laid-off ☐ Quit ☐ Fired ☐ Other:

The cost and amount of DES child care services will be based on the information provided on this wage statement. Please use the reverse, if necessary, to clarify any of the above information provided.

DES USE ONLY

CHILD CARE SPECIALIST	PHONE NO.	FAX NO.	SITE CODE
	( )	( )	

OFFICE ADDRESS *(No., Street, City, State, ZIP)*

CASE NAME *(Last, First, M.I.)*	CASE ID NO.

Equal Opportunity Employer/Program ◆ Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact (602) 542-4248; TTY/TDD Services: 7-1-1.